

TABLE I. Probability of Difficult Endotracheal Intubation by Results of Preoperative Airway Assessment[†]

Protruding maxilla (thalassemia)	Prominent upper teeth	Head and neck mobility <90°	TMD ^a <6.5 cm	Long narrow mouth	Airway pathology ^b	Obesity BMI ^c ≥34	IG ^d <3.5 cm	Multiple risk factors	Absence of risk factors
6/32 (18.8)	5/37* (13.5)	11/54* (20.4)	17/60* (28.3)	4/28* (14.3)	19/86* (22.1)	14/156** (9.0)	9/12** (75.0)	25/64 (39.1)	42/4,637 (0.9)

[†]Numbers in parentheses are percentages.

^aThyromental distance.

^bExtremely large goiter and other causes of deviation and/or stenosis of larynx or trachea.

^cBody mass index.

^dInterincisors gap (mouth opening).

* χ^2 , Nonsignificant, as compared with thalassemia.

** χ^2 , $P < 0.001$, as compared with thalassemia.

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An Unusual Case of Untreated Chronic Lymphocytic Leukemia Patient Presenting With *Rhodococcus equi* Bacteriemia

To the Editor: The emerging role of rare opportunistic microorganisms in immunocompromised hosts was recently reported in your journal [1]. We present the case of a human immunodeficiency virus (HIV)-negative untreated chronic lymphocytic leukemia (CLL) patient (stage IV Rai classification) with *Rhodococcus equi* (RE) bacteriemia at presentation. RE, a well-described veterinary pathogen, is an intracellular facultative, gram-positive, partially acid-fast coccobacillary microorganism that in immunocompromised human patients may be responsible for bacteremia and invasive pulmonary, extrapulmonary, and disseminated infections [2]. Most cases were recorded among HIV-positive patients and in hemolymphopathic subjects after chemotherapy [3].

A 57-year-old married man was admitted with a 2-month history of abdominal tension and distalis edema because of the occasional finding of hyperleukocytosis ($660 \times 10^3/\mu\text{l}$). He was a retired nurse and had had no apparent exposure to RE sources of infection. On physical examination, he was found to have significant polydistrictal lymphadenopathies, hepato- and splenomegaly. Pulmonary examination and chest radiography revealed a right pleural effusion. Blood cell differential demonstrated absolute lymphocytosis (L 98%) with diffuse bone marrow substitution. By flow cytometry a typical immunological CLL pattern (CD5+/CD19+, CD23+, HLA-DR+ with dim surface immunoglobulin expression) was demonstrated. CD4+ lymphocytes were 6,460/ μl . IgG nephelometric determination was 392 mg/dl (normal range 614–1,290 mg/dl). Because of a single febrile episode ($>38^\circ\text{C}$), the patient underwent a blood microbiological culture with the unexpected isolation of the RE. After counseling, the patient was tested for HIV antibody by enzyme-linked immunosorbent assay (ELISA) and found to be negative. The patient was HBV negative and HCV positive. On the basis of the antibiogram, the patient was treated for 2 months with trimethoprim/sulfamethoxazole. No fever was observed during the entire period, and all subsequent blood and sputum cultures resulted negative. Two months later, following 2 COP (cyclophosphamide, vincristine, and prednisone) and one CNOP (COP plus mitoxantrone) chemotherapeutic regimens, the patient died of severe hepatic failure. No autopsy was done.

Few cases of RE infection have been reported in HIV-negative patients; these cases were previously treated hematologic patients. To our knowledge, this is the first case of an untreated CLL patient presenting with RE infection. In our opinion, the importance of this case is related to the role of rare opportunistic pathogens in hemolymphopathic disorders both at diagnosis and during treatment. Hematological patients, and in particular CLL patients, are by definition immunodeficient subjects in which pulmonary infections and septicemia represent the principal causes of death. The importance of considering rare opportunistic infections, and in particular RE infection, in hematological patients [4] is also related to a possible frequent occupational and leisure time exposition to RE (contact with horses, sheep, pens, and animal manure in the activities of farmers and gardeners).

Isolated bacteriemia may be a manifestation of latent infection during a period of immunologic depression. RE diagnosis is often delayed because of an insidious course of the infection and of the difficult microbiological identification, since it may be mistaken for a difteroid or occasionally for a mycobacterium based on acid fast resistance. The efficacy of the therapy is strictly related to a rapid diagnosis; it depends on prolonged treatment and on the use of lipophilic antimicrobial drugs that can penetrate the macrophages or neutrophils in which the organisms survive [5]. In conclusion RE infection should be considered an important emerging opportunistic infection in both untreated and treated hematologic patients.

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